

CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability
(To be filled in block letters)

DETAILS OF PRIMARY INSURED																						
a) Policy No.												b) Sl. No./Certificate No.										
c) Company/TPA ID No.																						
d) Name																						
e) Address																						
	City																					
	State																			Pin Code		
	Ph. No.																			Email ID		

DETAILS OF INSURANCE HISTORY															
a) Currently covered by any other Mediclaim/Health Insurance												Yes		No	
b) If yes, Company Name															
Policy No.												Sum Insured (₹)			
c) Date of commencement of first Insurance without break												DD / MM / YYYY		(Copies of Policies to be attached)	
d) Have you been hospitalized in the last 4 years? (since inception of the contract)												Yes		No	
												Date	DD / MM / YYYY		
												Diagnosis			
e) Have you been covered by any other Mediclaim/Health Insurance in last 4 years												Yes		No	
f) If yes, Company Name															

DETAILS OF INSURED PERSON HOSPITALIZED													
a) Name													
b) Gender	Male		Female		c) Age	years		months		d) Date of Birth	DD / MM / YYYY		
e) Relationship to Primary insured	Self		Spouse		Child		Father		Mother				
	Other		(Please Specify)										
f) Occupation	Service		Self Employee		Homemaker		Student		Retired				
	Other		(Please Specify)										
Address (if different from above)													
	City												
	State												Pin Code
	Ph. No.												Email ID

DETAILS OF HOSPITALIZATION													
a) Name of Hospital where Admitted													
b) Room Category occupied	Day Care		Single occupancy		Twin sharing		3 or more beds per room						
c) Hospitalization due to	Injury		Illness		Maternity								
d) Date of Injury/Date of Disease first detected/Date of Delivery												DD / MM / YYYY	
e) Date of Admission	DD / MM / YYYY		f) Time	HH	MM	g) Date of Discharge	DD / MM / YYYY		h) Time	HH	MM		
i) If injury give cause	Self inflicted		Road Traffic Accident										
	Substance Abuse/Alcohol consumption		i. if Medico legal		Yes		No						
ii. Reported to police	Yes		No		iii. MLC Report & Police FIR attached		Yes		No				
j) System of Medicine													
k) Date of Surgery	DD / MM / YYYY		l) Claim Intimated		Yes		No						
i. Intimated to whom	SBU		Intermediaries		Call Centre		Health Claims Team						
ii. Intimation No. & date												DD / MM / YYYY	
iii. If not Intimated, reason?													

DETAILS OF CLAIM															
a) Details of the treatment expenses claimed															
i. Pre-hospitalization Expenses	₹							ii. Hospitalization Expenses	₹						
iii. Post-hospitalization expenses	₹							iv. Health-Check up Cost	₹						
v. Ambulance Charges	₹							vi. Others (code)							
vii. Pre-hospitalization period	days							Total	₹						
								viii. Post hospitalization period	days						
b) Claim for Domiciliary Hospitalization			Yes		No		(If yes, provide details in annexure)								
c) Details of Lump sum/cash benefit claimed															
i. Hospital Daily Cash	₹							ii. Surgical Cash	₹						
iii. Critical Illness Benefit	₹							iv. Convalescence	₹						
v. Pre/Post hospitalization Lump sum benefit	₹							vi. Others							
									Total	₹					
Claim Documents Submitted - Check List								Operation Theatre Notes							
Claim Form Duly signed								ECG							
Copy of the claim intimation								Doctor's request for investigation							
Hospital Main Bill								Investigation Reports (CT/MRI/USG/HPE)							
Hospital Break - up Bill								Doctor's Prescriptions							
Hospital Bill Payment Receipt								Pre-Hosp. Bills							
Hospital Discharge Summary								Post-Hosp. Bills							
Pharmacy Bill								Others							

DETAILS OF BILLS ENCLOSED						
Sl. No.	Bill No.	Date	Issued by	Towards (Hospitalization/Pre-hospitalization/Post-hospitalization)	Amount (₹)	
1		<u>DD / MM / YYYY</u>				
2		<u>DD / MM / YYYY</u>				
3		<u>DD / MM / YYYY</u>				
4		<u>DD / MM / YYYY</u>				
5		<u>DD / MM / YYYY</u>				
6		<u>DD / MM / YYYY</u>				
7		<u>DD / MM / YYYY</u>				
8		<u>DD / MM / YYYY</u>				
9		<u>DD / MM / YYYY</u>				
10		<u>DD / MM / YYYY</u>				

Do you want to opt for Automatic Reinstatement of Sum Insured in the event of a claim? If, Yes, applicable premium at short period rates would be deducted from the claim amount due to you. This reinstated sum will not be available for the same hospitalization. It will be available for treatment (other than certain chronic diseases) including the same illness or disease but separate independent case of hospitalization which are not case of relapse within 45 days of first hospitalization. Please contact the agent/our office for further details:

Yes
 No

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT (Please submit a cancelled cheque copy for NEFT)											
a) PAN				b) Account Number							
c) Bank Name and Branch											
d) Cheque/DD Payable details						e) IFSC Code					

DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA/Insurance company, to seek necessary medical information/documents from any hospital/Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills/receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Place: _____ Date: DD/MM/YYYY


 Signature of the Insured

Important:

- Please submit copy of valid Photo ID.
- For claimed amount above 1 lac, it is mandatory to submit the KYC (Know your customer) form.

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of this Form is not to be taken as an admission of liability
(To be filled in block letters)

Please include the original preauthorization request form in lieu of PART A

DETAILS OF HOSPITAL																				
a)	Name of the Hospital																			
b)	Hospital ID					c)	Type of Hospital	Network		Non Network		(If non network fill section E)								
d)	Name of the treating doctor																			
e)	Qualification					f)	Registration No. with State Code					g)	Ph No.							

DETAILS OF THE PATIENT ADMITTED																			
a)	Name of the Patient																		
b)	IP Registration Number					c)	Gender	Male		Female		d)	Age	Years		Months			
e)	Date of birth					DD / MM / YYYY	f)	Date of Admission					DD / MM / YYYY	g)	Time	HH	MM		
h)	Date of Discharge					DD / MM / YYYY	i)	Time					HH	MM					
j)	Type of Admission	Emergency		Planned		Day Care		Maternity											
k)	If Maternity	i. Date of Delivery				DD / MM / YYYY	ii. Gravida Status												
l)	Status at time of discharge	Discharge to home		Discharge to another hospital		Deceased													
m)	Total Claimed Amount					₹													

DETAILS OF AILMENT DIAGNOSED (PRIMARY)																			
a)	ICD 10 Codes										Description								
i.	Primary Diagnosis																		
ii.	Additional Diagnosis																		
iii.	Co-morbidities																		
iv.	Co-morbidities																		
b)	ICD 10 Codes										Description								
i.	Procedure 1																		
ii.	Procedure 2																		
iii.	Procedure 3																		
iv.	Details of Procedure																		
c)	Present ailment is a complication of PED?					Yes		No		(If Yes, specify details)									
d)	Pre-authorization obtained					Yes		No											
e)	Pre-authorization Number																		
f)	If authorization by network hospital not obtained, give reason																		
g)	Hospitalization due to Injury		Yes		No		i. If Yes, give cause			Self-inflicted		Road Traffic Accident							
	Substance abuse/alcohol consumption				ii. If Injury due to Substance abuse/alcohol consumption. Test Conducted to establish this					Yes		No		(If Yes, attach reports)					
	iii. If Medico legal		Yes		No		iv. Reported to Police		Yes		No		v. FIR No.						
	vi. If not reported to police give reason																		

CLAIM DOCUMENTS SUBMITTED - CHECK LIST			
Claim Form duly signed		Operation Theatre notes	Doctor's reference slip for investigation
Original Pre-authorization request		Hospital main bill	ECG
Copy of the Pre-authorization approval letter		Hospital break-up bill	Pharmacy bills
Copy of photo ID card of patient verified by hospital		Investigation reports	MLC report & Police FIR
Hospital Discharge summary		CT/MR/USG/HPE investigation reports	Original death summary from hospital where applicable
Any other, please specify			

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (Only fill in case of non-network hospital)															
a)	Address of the Hospital														
	City														
	State										Pin Code				
b)	Phone No.				c) Registration No.										
	Date of Registration			DD / MM / YYYY			Expiry date of Registration			DD / MM / YYYY					
	Name of the Registering Authority														
d)	PAN				e) Number of Inpatient beds										
f)	Facilities available in the hospital				i. OT		Yes	No	ii. ICU		Yes	No			
	iii. Others														

DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Hospital have required infrastructure to fulfill the hospital definition as per IRDA guideline, which is reproduced below:

- Has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places
- Has fully qualified nursing staff under its employment round the clock
- Has fully qualified doctor(s) in charge round the clock
- Has a fully equipped operation theatre of its own where surgical procedures are carried out.
- Maintains daily Medical records of patients and will make these accessible to the Company's authorized personnel.

Place: _____

Date: DD/MM/YYYY

Signature of Insured/Claimant

Signature and Seal of the Hospital Authority